OAH 48-0900-30683

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Cerenity Care Center on Humboldt

RECOMMENDED DECISION

Survey Exit Date: April 26, 2013

This matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Steve M. Mihalchick on November 21, 2013.

Christine Campbell, Division of Compliance Monitoring, appeared on behalf of the Minnesota Department of Health (the MDH or Department). Mary Cahill, Planner Principal with the Division of Compliance Monitoring; Michelle Ness, Supervisor; and Carrie Euerle, Investigator; also participated in the conference on behalf of the MDH.

Rebecca K. Coffin, Voigt, Rodè & Boxeth, LLC, appeared on behalf of Cerenity Care Center on Humboldt (the Facility). Ted Schmidt, Administrator; Michelle Frevert, RN, Director of Nursing Services (DON); and Faith Delpuerto, LPN (LPN-D), also participated in the conference on behalf of the Facility.

During the IIDR, the Facility referred to additional documentation of work shifts that was not in the record. The Judge asked the Facility to submit such documentation following the IIDR. The Facility did so by email on November 21, 2013, and offered the documentation as Exhibit 45. Both parties commented upon the submission by email on November 22, 2013. The OAH record was closed on November 22, 2013.

Based on the exhibits submitted and the arguments made and for the reasons set out in the Memorandum below, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

The Administrative Law Judge concludes that the "D" level deficiency issued under F-Tag 224, and the "G" level deficiency issued under F-Tag 323 are supported by the evidence and should be **AFFIRMED**.

Dated: January 10, 2014

s/Steve M. Mihalchick
STEVE M. MIHALCHICK
Administrative Law Judge

Reported: Digitally recorded (no transcript prepared).

NOTICE

In accordance with Minn. Stat. § 144A.10, subd. 16(d)(6), this recommended decision is not binding on the Commissioner of Health. As set forth in Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within ten calendar days of receipt of this recommended decision.

MEMORANDUM

Introduction

On March 1, 2013, the MDH initiated an abbreviated standard survey at the Facility to investigate a report of a leg injury Resident 1 (sometimes referred to as "R1") sustained while being transferred on a Hoyer lift (a brand of mechanical patient lift) on February 28, 2013. Following completion of the investigation on April 26, 2013, the MDH issued a Form CMS-2567, Statement of Deficiencies, to the Facility.[1] In this proceeding, the Facility challenges the deficiencies identified by F-Tags F 224 and F 323 relating to Resident 1.[2]

The F224 regulation, 42 C.F.R. § 483.13(c), requires the Facility to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. The MDH found that the Facility failed to ensure staff implemented policies and procedures that prohibited neglect when

[1] Exhibit (Ex.) E.
[2] Facility's letter brief to Administrative Law Judge, 11/14/13 (Facility's Brief) at 1.

Resident 1's plan of care was not followed during Resident 1's transfer on a Hoyer lift resulting in an injury.[3]

The F323 regulation, 42 C.F.R. § 483.25(h), requires the Facility to ensure that the resident environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents. The MDH found that the Facility failed to ensure adequate supervision was provided for Resident 1 during the mechanical (Hoyer) lift transfer that resulted in fractures of her right tibia and fibula.[4]

The Facility requests that the deficiencies issued be reversed arguing that it substantially complied with the requirements in F-tags 323 and 224 because it developed and implemented policies and procedures that prohibit mistreatment, neglect, and abuse of residents, and has sufficiently trained its staff to implement these policies and procedures, including following resident care plans. In particular, it argues that the Certified Nursing Assistant (CNA) staff member involved in the transfer at issue with Resident 1 (NA-A), was specifically trained how to transfer Resident 1, his supervisors made sure he continued to follow facility policies and procedures up to and including the day of the incident, and his failure to follow the Facility's policies and procedures and Resident 1's care plan were solely due to NA-A's misconduct and could not have been prevented by the Facility.[5]

The MDH position is that although the Facility had policies in place, the Facility failed to ensure the policies were implemented. MDH cites at least three Facility failures in that regard. First, even though Resident 1 was the only resident in the Facility whose care plan required three person assists with transfers on the Hoyer lift, which is different from the standard two person assist, all appropriate staff were not aware of that unique requirement. Second, Facility licensed staff was aware NA-A had difficulty understanding his care guide and although NA-A was trained to work with Resident 1, the Facility failed to supervise Resident 1's care to ensure that NA-A adhered to Resident 1's unique need for three-person assists with Hoyer lift transfers. Third, there is no evidence in NA-A's record that he was prepared to work independently and no longer required supervision of the residents' care that he was providing.[6]

Factual Background

Resident 1

Resident 1 is a 56-year-old woman with severe cognitive disabilities and several other diagnoses including osteoporosis, kyphosis, scoliosis, and epilepsy.[7] Resident 1 is unable to verbally communicate her needs and relies on others for all her care.[8] She

[3] Ex. E-1.
[4] Ex. E-5.
[5] Facility's Brief at 1.
[6] MDH Survey Claim Summary Chart filed with MDH Exhibits.
[7] Exs. 3 and 4.
[8] Ex. 1.

has been under state guardianship since 1960 and was moved to the Facility in 2007 due to the decline of her medical conditions of tubular sclerosis and seizure disorder.[9] Before moving to the Facility, Resident 1 lived at a home for disabled adults and then was hospitalized for a week for a spontaneous hip fracture. Her family preferred that she then move to the Facility, at least in part, because Resident 1's sister has worked at the Facility as a CNA since 1987. Resident 1's sister visits Resident 1 regularly, but does not provide direct cares to her.[10]

Resident 1 Three-Person Hoyer Transfer Requirement

Resident 1's bones are very fragile from the medications she has taken over the years to the extent that turning her over and repositioning can break a bone.[11] Thus, her care plan requires two staff to turn her in bed using a draw sheet.[12] Also because of Resident 1's condition, and to help prevent injuries upon transfer, she has required a three-person transfer on a Hoyer lift when moving her since her admission in 2007.[13] One staff member is to run the Hoyer lift, one is to guide Resident 1's legs, and one is to guide Resident 1's body.[14] The three-person Hoyer transfer requirement for Resident 1 is reflected on her Care Plan and on the daily CNA care cards that the lead or primary CNA for each resident group on a particular shift carries during that shift.[15] The care card forms used by the Facility have a note at the bottom that states: "2 people for all mechanical lifts and HOYER."[16]

Resident 1's sister and her Guardian continue to be very happy with her care at the Facility, even after the injury at issue in this proceeding.[17]

NA-A's Safety Training Regarding Resident 1 Transfers

The Facility attempts to ensure that every staff member who will regularly be providing cares to Resident 1 knows about the requirement for Resident 1 to be transferred by three-person Hoyer transfer and is trained on three-person Hoyer transfers with Resident 1 specifically.[18]

NA-A started his employment as a CNA with the Facility on January 30, 2013, when he completed a Site Orientation of the Facility that included a 20 minute session on Safe Patient Handling.[19] He began Day 1 of Unit Orientation on January 31, 2013. His training that day addressed several safety issues related to transfers, including

[9] Ex. 2.
[10] Ex. 1.
[11] *Id.*
[12] Ex 4 at 7. (The two-person requirement for using a draw sheet does not appear on the care card); Ex. 7.
[13] Exs. 1, 5, and 6 at 6.
[14] Interview with LPN-D (Faith Delpuerto) on 4/22/2013, restated in CMS-2567 at E-4.
[15] Ex. 4 at 7 and 14, and Ex. 7.
[16] Ex. 7.
[17] Testimony (Test.) of Ted Schmidt, Administrator, and Michelle Frevert, RN, DON; Exs. 1 and 2.
[18] Test. of M. Frevert.
[19] Ex. 9.

observing and assisting with transfers of patients between wheelchair and bed with a transfer/gait belt, but not with lifts.[20] Day 2 of NA-A's Unit Orientation also included the following:

> X New hire to **watch & repeat demo** of use of E-Z LIFT and E-Z STAND.
>
> X Demonstrate how to use E-Z LIFT, use 2 people at all times unless care planned differently.
>
> X Demonstrate how to use E-Z STAND, use 2 people at all times unless care planned differently.[21]

NA-A completed that training and signed a statement that he had watched an E-Z LIFT and E-Z STAND video, had received E-Z LIFT and E-Z STAND training packets, and had a clear understanding of them.[22]

A Hoyer Lift and an E-Z LIFT are different brands of mechanical patient lifts. An E-Z STAND is a different type of equipment that helps a person to a standing position.[23]

Day 5 of NA-A's Unit Orientation occurred on February 12, 2013. That day Melissa Krug, CNA, was his "Mentor" for his training with seven of the residents in Group 1, to which his was to be assigned, which included Resident 1.[24] Ms. Krug specifically talked to NA-A about Resident 1 and explained to him that Resident 1 always requires a three-person transfer, that it is different from most other residents who require two-person transfers, and that Resident 1 requires three-person transfers because she is prone to fractures due to her medical history. She also informed NA-A that due to that medical history, aides must take extra caution when caring for her. Ms. Krug then had NA-A watch her and two other staff members complete a three-person transfer of Resident 1. It appeared to her that he understood how to do the transfer and the importance of using a three-person transfer for Resident 1.[25] When Ms. Krug trains new CNAs, she makes sure that they learn that they must review and understand each resident's care card every day before providing cares to the resident. She specifically showed NA-A that Resident 1's care card indicated that Resident 1 required a three-person transfer.[26]

Day 6 of Orientation occurred on February 14, 2013, and NA-A worked with a different group of seven residents with [Taylor] Godfrey as Mentor. No evaluation notes were entered that day.

The last entry in NA-A's Unit Orientation Guide was for Day 7 on February 17, 2013. The notes by his Mentor that day, Whitney [Vought], indicate that NA-A was to

[20] Ex. 11 at Day 1. Ex. 11 is also Ex. L.
[21] Ex. 11 at Day 2.
[22] Ex. 8. The date that NA-A signed this statement apparently was corrected by NA-A, but is not clear.
[23] Test. of LPN-D.
[24] Ex. 11 at Day 5, Ex. 13.
[25] Exs. 12 and 13.
[26] Ex. 13.

"Work on group 2 w/6 residents" and that he "did good, very independent."[27] Ms. Vought had also been his Mentor on Day 2. She later stated that she had trained NA-A and made him aware that Resident 1 was to be transferred with three people at all times and that he is to look and follow the care plan for all residents.[28]

NA-A had an eighth day of Unit Orientation training on February 19, 2013, that was not recorded on his Unit Orientation Guide. There is no evidence as to the nature of his training that day other than it was with Ms. Krug. [29]

February 28, 2013, Injury to Resident 1

NA-A began working independently on the floor on February 21, 2013. A nurse manager apparently went over the "Humboldt Campus Safety Training" checklist with NA-A that day, which NA-A signed.[30]

On February 26 and 28, 2013, NA-A was assigned to be the primary CNA for the third floor Group 1 residents, including Resident 1, on the PM shift.[31] LPN-D was the "East Nurse" on duty those days and worked with NA-A. She is very familiar with Resident 1.[32] During orientation, CNAs are taught that the licensed nurse is their "team leader."[33]

There are differences in the witnesses' descriptions of the sequence of events on February 28, 2013, but the following is the most likely. At one point, LPN-D noticed the bathroom call light go on for Room 307, another room in Group 1. She went to Room 307 where she found one of the two residents of the room on the toilet hooked up to an EZ-STAND. That was improper because that resident's transfer instructions on the care card require his transfers to be done by two-person Hoyer assist.[34] LPN-D found NA-A in Room 309, Resident 1's room. She informed him that use of the EZ-STAND to transfer the resident in Room 307 had been improper and that that resident required a two-person assist with a Hoyer. LPN-D told NA-A that he should refer to the care cards for his residents and that at least two staff people are required for all Hoyer transfers. She asked if he had his care card with him and he did. She thought that NA-A may have misread a care card entry for the Room 307 resident that states, "EZ boots to both feet at night; NO EZ BOOTS when in WC," as somehow applying to the EZ-STAND.[35]

Later that day, LPN-D and another nurse who was in training with LPN-E (LPN-E) went to Resident 1's room to administer her medications to her. NA-A was alone in the room with Resident 1 putting the Hoyer sling under Resident 1 to get her ready for

[27] Ex. 11 at Day 7.
[28] Ex. 32.
[29] Test. of M. Frevert. Post IIDR filed Ex. 45 confirms that NA-A worked in orientation status on February 19, 2013, and worked "on the floor" on February 21 and 22, 2013.
[30] Ex. 10.
[31] Exs. 7, 15, and 16.
[32] Test. of LPN-D.
[33] Ex. 11 at Day 1.
[34] Test of LPN-D, Ex. 14, interview with LPN-D restated at CMS-2567 at E-4 – E-5.
[35] Test of LPN-D, Ex. 14.

transfer from her bed to her wheelchair. LPN-A noted that repositioning Resident 1 required two people, but said nothing about it. LPN-D did inform NA-A that Resident 1 was a three-person assist with a Hoyer lift because of her osteoporosis and fragile bones. LPN-D and LPN-E offered to help NA-A with the transfer of Resident 1. The three of them transferred Resident 1 to her wheelchair without incident.[36]

Still later on February 28, 2013, NA-A asked another CNA, NA-B, to assist him transfer Resident 1.[37] NA-B had started at the Facility several weeks before NA-A. She completed her Site Orientation on November 7, 2012, and then completed six days of Unit Orientation. None of her orientation days with patients included Resident 1.[38] NA-B was not aware that Resident 1's care plan required the use of three-person assists on the Hoyer because she had not worked with Resident 1. She understood that all other residents in the Facility that require the use of a Hoyer lift for transfers require two-person assists.[39]

When NA-B entered the room to help, NA-A already had Resident 1, who was in her wheelchair, hooked up to the Hoyer. NA-B went behind Resident 1 to guide Resident 1's body while NA-A was in front operating the Hoyer. As they were lifting Resident 1 from the wheelchair, Resident 1's foot bumped or caught on the control box of the Hoyer lift and Resident 1 “cried out” or "let out a shriek." NA-B could not see exactly what had happened from the back. NA-A lowered Resident 1, then NA-B and NA-A readjusted her. They then completed the transfer from the wheelchair to the bed. Neither reported the incident.[40]

At some point, LPN-D came into Resident 1's room when Resident 1 was in bed and NA-A and NA-B were in the room. LPN-D assumed that Resident 1 had been transferred by three staff persons and apparently did not ask about it.[41] LPN-D later told the MDH investigator that she had spoken with NA-A after Resident 1's transfer, regarding reading of the resident's care card.[42] It is not clear which transfer of Resident 1 that statement refers to. The only evidence of LPN-D telling NA-A that Resident 1 required a three-person Hoyer assist is that she did it only the time that she and LPN-E helped NA-A with the transfer to the wheelchair earlier in the day. Later that evening, LPN-D left a voice mail for the Clinical Manager reporting NA-A's error in using an EZ-STAND instead of a Hoyer lift with the resident in Room 307.[43]

[36] Exs. 14, 22 (2/28 entry), 23, and 33, Test. of LPN-D.
[37] Interview with NA-B restated at CMS-2567 at E-3 – E-4; Interview with NA-A restated at CMS-2567, Exs. E-2 – E-3.
[38] Exs. 25, 26, 27 and 28.
[39] Interview with NA-B restated at CMS-2567 at E-3 – E-4.
[40] Ex. 24; interview with NA-B restated at CMS-2567 at E-3 – E-4.
[41] Interview with LPN-D restated at CMS-2567 at E-4 – E-5.
[42] Interview with LPN-D restated at CMS-2567 at E-5.
[43] Test. of LPN-D.

Discovery and Investigation of Injury

In the morning of March 1, 2013, a CNA performing morning cares noticed a bruise on Resident 1's right leg near her ankle and informed a registered nurse (RN). The RN assessed the bruise and contacted a nurse practitioner who ordered x-rays.[44]

Another RN promptly began an investigation of the bruising by interviewing staff about the incident. She interviewed NA-A and NA-B by phone.[45] The investigating RN completed a Resident Injury Investigation Report reporting that her investigation to that point revealed that the bruise resulted from the transfer of Resident 1 from wheelchair to bed the previous evening.[46] The Facility received the Radiology Report about 11:52 a.m. It stated that there were fractures of the distal tibia and fibula (just above the ankle) with no significant displacement, that joint alignment was maintained, and that there was associated soft tissue swelling. The Radiology Report described the injury as "ankle fractures."[47] The investigating RN called Resident 1's guardian and informed her of the fractures and the investigation.[48] The RN promptly reported the incident to the MDH Office of Health Facility Complaints, which she described as follows:

> Bruise discovered on resident's right medial extremity at approximately 8:15 am. RN initiated investigation to reveal reason for bruise. It was determined that during transfer into residents bed, [Resident 1's] leg hit hoyer bar and she in turn sustained a fracture. The Care plan was not being followed as it indicates three staff are to assist with transfer and only two persons were assisting with transfers. All parties notified and investigation initiated.

At 1:00 p.m., the MDH confirmed receipt of the incident report.[49]

On March 1, 2013, Resident 1 was evaluated by an orthopedic nurse practitioner who noted that Resident 1 grimaced and cried out when her right ankle was moved. She applied a short leg cast and ordered ice and checks every shift and that three-person transfers continue.[50] The Facility documented the investigation and treatment for Resident 1's fracture in the Resident Progress Notes.[51]

NA-A resigned his position after this incident and no longer is employed at the Facility.[52]

NA-A later told the MDH investigator that February 28, 2013, was the first time that he had worked alone as the primary nursing assistant on Resident 1's group and

[44] Ex. 22.
[45] Exs. 23 and 24.
[46] Ex. 17.
[47] Ex. 21.
[48] Ex. 22.
[49] Ex. 19.
[50] Exs. 20 and 21.
[51] Ex. 22.
[52] Test. of M. Frevert.

that he did not realize until speaking with the DON after Resident 1's fracture was discovered that Resident 1 required the assistance of three staff members when using the Hoyer lift. He also said that during orientation, when observing Resident 1 being transferred, three staff did not assist with completing the transfer of Resident 1.[53] These statements are not credible in light of the statements of other witnesses.

Discussion

F224

The F224 regulation requires the facility to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.[54] Further, the facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.[55] "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.[56]

Thus, the Facility must adopt and implement policies and procedures that prevent neglect. The Facility had policies for abuse and neglect and policies for safe transfers. It had a plan for safe transfers of Resident 1 that was unique in the Facility. However, the Facility failed to ensure the policy regarding Resident 1 was implemented. It failed to provide services necessary to avoid physical harm. By failing to ensure the individualized resident care plan was followed, the Facility failed to provide services to avoid harm. The failure to ensure the care plan was implemented resulted in Resident 1's fractures.

Resident 1's care plan and the Group 1 care card specified that her transfers were to be by three-person assist with the Hoyer lift. During his eight days of Site Orientation and Unit Orientation, NA-A only worked with the Group 1 residents once. Resident 1 was just one of the seven residents in the group that day. NA-A was told about Resident 1's three-person assist requirement at least once and it was demonstrated to him once. He "seemed to understand it," but he was never required to demonstrate that he knew how to do it or that he knew that the third person was necessary to guide Resident 1's legs and feet. He was told to read the care card, but that instruction is not on the care card.

On February 28, 2013, NA-A finally got specific instructions from LPN-D and participated in a three-person lift. But that occurred because LPN-D and LPN-E happened to come in while he was already engaged in putting the Hoyer sling under Resident 1 by himself. She did not tell him that even repositioning Resident 1 required a second person. She did tell him that three people were required for the transfer. After some discussion, the two LPNs helped NA-A with the transfer. This was NA-A's fourth day of working in Group 1, and his second day of being the primary CNA for the group.

[53] Interview with NA-A restated at CMS-2567, Exs. E-2 – E-3.
[54] 42 C.F.R. § 483.13(c).
[55] 42 C.F.R. § 483.13(c)(i).
[56] 42 C.F.R. § 488.301.

The Facility's plan does not require that CNAs get more specific training when they first start on a floor or in a group. There is no evidence that NA-A received any specific training about Resident 1 when he started, or about the three-person Hoyer assist requirement. There is no evidence that any nurse on duty or any experienced CNA observed to make sure that Resident 1's transfers were done correctly by NA-A. As the MDH puts it, there is no evidence that NA-A's knowledge and skill set was reviewed to determine if he was ready to be independent when working with Resident 1.

Moreover, the fact that NA-B assisted with the second transfer that day and was unaware Resident 1 required a three-person Hoyer lift is another failure to ensure the care plan was implemented. For some reason she was around to help with a resident she did not know. It was not her responsibility, but where there is one resident with a requirement different from every other resident, and that requirement addresses a high risk, that difference must be made clear to all staff that might become involved. Perhaps a sign on the Hoyer that three people were required for Resident 1. The Facility did not ensure that the Hoyer would be used properly for Resident 1.

Scope and severity level D applies to an isolated deficiency that results in no more than minimal harm and/or has the potential (not yet realized) to compromise the residents ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

The Facility's failures meet the definition of neglect. The deficiency should be affirmed as written at a scope and severity of D.

F323

The F323 regulation[57] requires the Facility to ensure that the resident environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents.

The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:

- Identifying hazard(s) and risk(s);
- Evaluating and analyzing hazard(s) and risk(s);
- Implementing interventions to reduce hazard(s) and risk(s); and
- Monitoring for effectiveness and modifying interventions when necessary.

[57] 42 C.F.R. § 483.25(h).

The federal guidance for this requirement defines an avoidable accident as an accident that occurred because the facility failed to:

- Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and/or
- Evaluate/analyze the hazards and risks; and/or
- Implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident; and/or
- Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice.[58]

"Supervision/Adequate Supervision" refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency, based on the individual resident's assessed needs, and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. Tools or items such as personal alarms can help to monitor a resident's activities, but do not eliminate the need for adequate supervision.[59]

- The frailty of some residents increases their vulnerability to hazards in the resident environment and can result in life threatening injuries. It is important that all facility staff understand the facility's responsibility, as well as their own, to ensure the safest environment possible for residents.[60]

Adequate supervision to prevent accidents is enhanced when the facility:

- Accurately assesses a resident and/or the resident environment to determine whether supervision to avoid an accident is necessary; and/or
- Determines that supervision of the resident was necessary and provides supervision based on the individual resident's assessed needs and the risks identified in the environment.[61]

The federal guidance addresses assistive devices, in part, as follows:

[58] Ex. G-2.
[59] Ex. G-3.
[60] Ex. G-3.
[61] Ex. G-7.

> Training of staff, residents, family members and volunteers on the proper use of assistive devices/equipment is crucial to prevent accidents. It is also important to communicate clearly the approaches identified in the care plan to all staff, including temporary staff. It is important to train staff regarding resident assessment, safe transfer techniques, and the proper use of mechanical lifts including device weight limitations.[62]
>
> Factors that may influence a resident's risk of accident during transfer include staff availability, resident abilities, and staff training**.**[63]

The Facility is responsible to minimize the risk of avoidable accidents. Soon after Resident 1's admission in 2007, the Facility assessed Resident 1's need for three-person Hoyer transfers. It followed the orders and recommendations of other health care professionals in that regard and incorporated the requirement in Resident 1's care plan. There were no problems until 2013. But the injury to Resident 1 on February 28, 2013, revealed that there was inadequate monitoring to ensure that Resident 1 was consistently being transferred with three-person Hoyer assists. Resident 1 was not monitored or supervised to ensure that her unique care plan was consistently and continuously implemented.

As the MDH argues, this accident was potentially avoidable. Had the third staff person required for the transfer been assisting, particularly by Resident 1's legs and feet, it is likely that her foot would not have bumped or become hung up on the Hoyer and the fractures would have been avoided. Two facility staff transferred Resident 1 without a third person assisting. The two CNAs involved in the transfer resulting in the fractures did not appreciate or did not know of the need for a three-person assist on the transfer. The Facility had no system in place to ensure that staff was aware of the individualized needs of Resident 1. All staff able to assist with transfers should have been aware of Resident 1's unique need due to her high risk for fracture.

Scope and severity level G applies to an isolated deficiency that results in a negative outcome that has compromised the residents ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

This was an avoidable accident. The failure to prevent the accident resulted in harm for Resident 1 as evidenced by the pain she had from the fracture. Resident 1 had a negative outcome that compromised her ability to maintain and/or reach her highest well-being. The deficiency should be affirmed as written at a scope and severity of G.

S.M.M.

[62] Exs. G-14 – G-15.
[63] Ex. G-15.